

require the provision of data to public health authorities.

(July 1, 1944, ch. 373, title XXVI, § 2695G, as added Pub. L. 111-87, § 13, Oct. 30, 2009, 123 Stat. 2902.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective as if enacted on Sept. 30, 2009, see section 2(a)(3)(B) of Pub. L. 111-87, set out as an Effective Date of 2009 Amendment; Revival of Section note under section 300ff-11 of this title.

§ 300ff-139. Injunctions regarding violation of prohibition

(a) In general

The Secretary may, in any court of competent jurisdiction, commence a civil action for the purpose of obtaining temporary or permanent injunctive relief with respect to any violation of this part.

(b) Facilitation of information on violations

The Secretary shall establish an administrative process for encouraging emergency response employees to provide information to the Secretary regarding violations of this part. As appropriate, the Secretary shall investigate alleged such¹ violations and seek appropriate injunctive relief.

(July 1, 1944, ch. 373, title XXVI, § 2695H, as added Pub. L. 111-87, § 13, Oct. 30, 2009, 123 Stat. 2902.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective as if enacted on Sept. 30, 2009, see section 2(a)(3)(B) of Pub. L. 111-87, set out as an Effective Date of 2009 Amendment; Revival of Section note under section 300ff-11 of this title.

§ 300ff-140. Applicability of part

This part shall not apply in a State if the chief executive officer of the State certifies to the Secretary that the law of the State is substantially consistent with this part.

(July 1, 1944, ch. 373, title XXVI, § 2695I, as added Pub. L. 111-87, § 13, Oct. 30, 2009, 123 Stat. 2903.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective as if enacted on Sept. 30, 2009, see section 2(a)(3)(B) of Pub. L. 111-87, set out as an Effective Date of 2009 Amendment; Revival of Section note under section 300ff-11 of this title.

SUBCHAPTER XXV—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

Editorial Notes

CODIFICATION

Pub. L. 104-204, title VI, § 604(a)(1), Sept. 26, 1996, 110 Stat. 2938, substituted “REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE” for “ASSURING PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH INSURANCE COVERAGE” as subchapter heading.

¹ So in original.

PRIOR PROVISIONS

A prior subchapter XXV (§300aaa et seq.), comprised of title XXVII of the Public Health Service Act, act July 1, 1944, ch. 373, §§2701 to 2714, was renumbered title II, part B, §§231 to 244, of the Public Health Service Act, and transferred to part B (§238 et seq.) of subchapter I of this chapter.

PART A—INDIVIDUAL AND GROUP MARKET REFORMS

Editorial Notes

CODIFICATION

Pub. L. 111-148, title I, §1001(1), Mar. 23, 2010, 124 Stat. 130, substituted “Individual and Group Market Reforms” for “Group Market Reforms” in part heading.

SUBPART I—GENERAL REFORM

Editorial Notes

CODIFICATION

Pub. L. 111-148, title I, §§1201(1), 1255, formerly §1253, title X, §10103(e), (f)(1), Mar. 23, 2010, 124 Stat. 154, 162, 895, substituted “SUBPART I—GENERAL REFORM” for “SUBPART I—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS” in subpart heading, effective for plan years beginning on or after Jan. 1, 2014.

§ 300gg. Fair health insurance premiums

(a)¹ Prohibiting discriminatory premium rates

(1) In general

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg-6(c) of this title); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) Rating area

(A) In general

Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this subchapter.

(B) Secretarial review

The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this subchapter. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

¹ So in original. No subsec. (b) has been enacted.

(3) Permissible age bands

The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) Application of variations based on age or tobacco use

With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) Special rule for large group market

If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 18032(f)(2)(B) of this title), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

(July 1, 1944, ch. 373, title XXVII, §2701, as added and amended Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892.)

Editorial Notes**PRIOR PROVISIONS**

A prior section 300gg, act July 1, 1944, ch. 373, title XXVII, §2701, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1955; amended Pub. L. 111-3, title III, §311(b)(2), Feb. 4, 2009, 123 Stat. 70; Pub. L. 111-5, div. B, title I, §1899D(c), Feb. 17, 2009, 123 Stat. 426; Pub. L. 111-344, title I, §114(c), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112-40, title II, §242(a)(3), Oct. 21, 2011, 125 Stat. 419, which related to increased portability through limitation on preexisting condition exclusions, was renumbered section 2704 of act July 1, 1944, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title.

Another prior section 2701 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238 of this title.

AMENDMENTS

2010—Subsec. (a)(5). Pub. L. 111-148, §10103(a), inserted “(other than self-insured group health plans offered in such market)” after “such market”.

Statutory Notes and Related Subsidiaries**EFFECTIVE DATE**

Pub. L. 111-148, title I, §1255, formerly §1253, title X, §10103(e), (f)(1), Mar. 23, 2010, 124 Stat. 162, 895, provided that: “This subtitle [subtitle C (§§1201-1255) of title I of Pub. L. 111-148, enacting subchapter II of chapter 157 of this title and sections 300gg-2 and 300gg-4 to 300gg-7 of this title, and amending sections 300gg-1 and 300gg-4 of this title and transferring former section 300gg of this title to section 300gg-3 of this title] (and the amendments made by this subtitle) shall become effective for plan years beginning on or after January 1, 2014, except that—

“(1) section 1251 [enacting section 18011 of this title] shall take effect on the date of enactment of this Act [Mar. 23, 2010]; and

“(2) the provisions of section 2704 of the Public Health Service Act [42 U.S.C. 300gg-3] (as amended by

section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act [Mar. 23, 2010].. [sic]”

Pub. L. 104-191, title I, §102(c), Aug. 21, 1996, 110 Stat. 1976, provided that:

“(1) IN GENERAL.—Except as provided in this subsection, part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as added by subsection (a)) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997.

“(2) DETERMINATION OF CREDITABLE COVERAGE.—

“(A) PERIOD OF COVERAGE.—

“(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as added by this section) in determining creditable coverage.

“(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Health and Human Services, consistent with section 104 [42 U.S.C. 300gg-92 note], shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

“(B) CERTIFICATIONS, ETC.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 2701 [now 2704] of the Public Health Service Act [42 U.S.C. 300gg-3(e)] (as added by this section) shall apply to events occurring after June 30, 1996.

“(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

“(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

“(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

“(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

“(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan’s or issuer’s crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section [enacting this section and sections 300gg-1, 300gg-11 to 300gg-13, 300gg-21 to 300gg-23, 300gg-91, and 300gg-92 of this title and amending sections 300e and 300bb-8 of this title].

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2)(B), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (other than section 2701(e) [now 2704(e)] thereof [42 U.S.C. 300gg-3(e)]) shall not apply to plan years beginning before the later of—

“(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension

thereof agreed to after the date of the enactment of this Act), or

“(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

“(4) **TIMELY REGULATIONS.**—The Secretary of Health and Human Services, consistent with section 104 [42 U.S.C. 300gg-92 note], shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section [enacting this section and sections 300gg-1, 300gg-11 to 300gg-13, 300gg-21 to 300gg-23, 300gg-91, and 300gg-92 of this title and amending sections 300e and 300bb-8 of this title] and section 111 [enacting sections 300gg-41 to 300gg-44 and 300gg-61 to 300gg-63 of this title].

“(5) **LIMITATION ON ACTIONS.**—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.”

CONGRESSIONAL FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY; SEVERABILITY

Pub. L. 104-191, title I, §195, Aug. 21, 1996, 110 Stat. 1991, provided that:

“(a) **FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.**—Congress finds the following in relation to the provisions of this title [enacting this subchapter and sections 1181 to 1183 and 1191 to 1191c of Title 29, Labor, amending sections 233, 300e, and 300bb-8 of this title and sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of Title 29, and enacting provisions set out as notes under this section, section 300gg-92 of this title, and section 1181 of Title 29]:

“(1) Provisions in group health plans and health insurance coverage that impose certain preexisting condition exclusions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

“(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

“(3) It is a necessary and proper exercise of Congressional authority to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

“(4) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

“(b) **SEVERABILITY.**—If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.”

HEALTH COVERAGE AVAILABILITY STUDIES

Pub. L. 104-191, title I, §191, Aug. 21, 1996, 110 Stat. 1987, directed the Secretary of Health and Human Services to provide for a study on the effectiveness of the provisions of title I of Pub. L. 104-191 and the various State laws, in ensuring the availability of reasonably priced health coverage to employers and individuals and a study on access to, and choice of, health care providers and the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network

providers, and the potential impact of providing such access on the cost and quality of health insurance coverage, and to report to the appropriate committees of Congress on each of such studies not later than Jan. 1, 2000.

§ 300gg-1. Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e),¹ each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) Enrollment

(1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of title 29).

(3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals¹ employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such

¹ So in original.

service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

(July 1, 1944, ch. 373, title XXVII, §2702, as added and amended Pub. L. 111-148, title I, §§1201(4), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 266, 911.)

Editorial Notes

CODIFICATION

The text of section 300gg-11 of this title, which was amended and transferred to subsecs. (c) and (d) of this section by Pub. L. 111-148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111-148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2731, formerly §2711, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1962; renumbered §2731, Pub. L. 111-148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 300gg-1, act July 1, 1944, ch. 373, title XXVII, §2702, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1961; Pub. L. 110-233, title I, §102(a)(1)-(3), May 21, 2008, 122 Stat. 888, 890, which related to prohibition on discrimination against individual participants and beneficiaries based on health status, was amended by Pub. L. 111-148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, effective for plan years beginning on or after Jan. 1, 2014, and was transferred to subsecs. (b) to (f) of section 300gg-4 of this title.

Another prior section 2702 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

AMENDMENTS

2010—Pub. L. 111-148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111-148, §10107(b)(1), trans-

ferred section 300gg-11 of this title to the end of this section after amending it by striking out the section catchline “Guaranteed availability of coverage for employers in group market”, by striking out subsec. (a) which related to issuance of coverage in small group market, subsec. (b) which related to assurance of access in large group market, subsec. (e) which related to exception to requirement for failure to meet certain minimum participation or contribution rules, and subsec. (f) which related to exception for coverage offered only to bona fide association members, by amending subsec. (c) by substituting “group and individual” for “small group” in introductory provisions of par. (1), inserting “and individuals” after “employers” in introductory provisions of par. (1)(B), inserting “or any additional individuals” after “additional groups” in par. (1)(B)(i), substituting “and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals” for “without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such” in par. (1)(B)(ii), and substituting “group or individual” for “small group” in par. (2), and by amending subsec. (d) by substituting “group or individual” for “small group” wherever appearing and substituting “all employers and individuals” for “all employers”, “those individuals, employers” for “those employers”, and “such individuals, employees” for “such employees” in par. (1)(B).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111-148, set out as a note under section 300gg of this title.

§ 300gg-2. Guaranteed renewability of coverage

(a) In general

Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums

The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud

The plan sponsor, or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rates

In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.

(4) Termination of coverage

The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

(5) Movement outside service area

In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).¹

(6) Association membership ceases

In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for uniform termination of coverage**(1) Particular type of coverage not offered**

In any case in which an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

(A) the issuer provides notice to each plan sponsor or individual, as applicable, provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor or individual, as applicable, provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of all coverage**(A) In general**

In any case in which a health insurance issuer elects to discontinue offering all

health insurance coverage in the individual or group market, or all markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if—

(i) the issuer provides notice to the applicable State authority and to each plan sponsor or individual, as applicable,² (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) Prohibition on market reentry

In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for uniform modification of coverage

At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(e) Application to coverage offered only through associations

In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(July 1, 1944, ch. 373, title XXVII, §2703, as added and amended Pub. L. 111-148, title I, §§1201(4), 1563(c)(9), formerly §1562(c)(9), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 267, 911.)

Editorial Notes

REFERENCES IN TEXT

Section 2711, referred to in subsec. (b)(5), is a reference to section 2711 of act July 1, 1944. Section 2711, which was classified to section 300gg-11 of this title, was renumbered section 2731 and amended and transferred by Pub. L. 111-148, title I, §§1001(3), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911, to the end of section 2702 of act July 1, 1944, as added by Pub. L. 111-148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, and classified to section 300gg-1 of this title. A new section 2711 of act July 1, 1944, related to no lifetime or annual limits, was added by Pub.

¹ See References in Text note below.

² So in original.

L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, and is classified to section 300gg-11 of this title.

CODIFICATION

The text of section 300gg-12 of this title, which was amended and transferred to subsecs. (b) to (e) of this section by Pub. L. 111-148, §1563(c)(9), formerly §1562(c)(9), as renumbered by Pub. L. 111-148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2732, formerly §2712, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1964; renumbered §2732, Pub. L. 111-148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 2703 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238b of this title.

AMENDMENTS

2010—Pub. L. 111-148, §1563(c)(9), formerly §1562(c)(9), as renumbered by Pub. L. 111-148, §10107(b)(1), transferred section 300gg-12 of this title to the end of this section after amending it by striking out the section catchline “Guaranteed renewability of coverage for employers in group market”, by striking subsec. (a) which required a health insurance issuer offering coverage in connection with a group health plan to renew such coverage at the option of the plan sponsor, by amending subsec. (b) by substituting “health insurance coverage offered in the group or individual market” for “group health plan in the small or large group market” in introductory provisions, inserting “, or individual, as applicable,” after “plan sponsor” in pars. (1) and (2), adding par. (3), and striking out former par. (3) which related to violation of participation or contribution rules, and by amending subsec. (c) by substituting “group or individual health insurance coverage” for “group health insurance coverage offered in the small or large group market” in introductory provisions of par. (1), inserting “or individual, as applicable,” after “plan sponsor” in par. (1)(A) and (B), inserting “or individual health insurance coverage” in par. (1)(B), inserting “or individuals, as applicable,” after “those sponsors” in par. (1)(C), substituting “individual or group market, or all markets,” for “small group market or the large group market, or both markets,” in introductory provisions of par. (2)(A), and inserting “or individual, as applicable,” after “plan sponsor” in par. (2)(A)(i). Amendment inserting “or individual health insurance coverage” in subsec. (c)(1)(B) was executed by making the insertion after “group health plan” as the probable intent of Congress, notwithstanding that the directory language did not specify where in subsec. (c)(1)(B) to make the insertion.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111-148, set out as a note under section 300gg of this title.

§ 300gg-3. Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term “preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1)¹ in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term “enrollment date” means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term “late enrollee” means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) Waiting period

The term “waiting period” means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) “Creditable coverage” defined

For purposes of this subchapter, the term “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of title 22.

¹ See References in Text note below.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg-91(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before January 1, 2014—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms “TAA-eligible individual” and “TAA-related loss of coverage” have the meanings given such terms in section 300bb-5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3),¹ a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3)¹ based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall

count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the individual or group group² market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

² So in original.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage**(1) Requirement for certification of period of creditable coverage****(A) In general**

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods**(1) Individuals losing other coverage**

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries**(A) In general**

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

- (i) the date dependent coverage is made available, or
- (ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

- (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
- (ii) in the case of a dependent's birth, as of the date of such birth; or
- (iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], or child health assistance under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 1181(f)(3)(B)(i)(II) of title 29.

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of title 29.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined

under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance³ Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act [42 U.S.C. 1397ee(c)(2)(B), (3), (10)] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

(July 1, 1944, ch. 373, title XXVII, §2704, formerly §2701, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1955; amended Pub. L. 111-3, title III, §311(b)(2), Feb. 4, 2009, 123 Stat. 70; Pub. L. 111-5, div. B, title I, §1899D(c), Feb. 17, 2009, 123 Stat. 426; renumbered §2704 and amended Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911; Pub. L. 111-344, title I, §114(c), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112-40, title II, §242(a)(3), (4), Oct. 21, 2011, 125 Stat. 419.)

Editorial Notes

REFERENCES IN TEXT

Subsection (a), referred to in subsecs. (b)(1)(B) and (c)(3)(A), (B), was struck out, and a new subsec. (a) was added, by Pub. L. 111-148, title I, §1201(2)(A), Mar. 23, 2010, 124 Stat. 154, and as so amended, subsec. (a) no longer contains paragraphs.

The Social Security Act, referred to in subsecs. (c)(1)(C), (D) and (f)(3)(A)(i), (B)(i)(I), (ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts A and B of title XVIII of the Act are classified generally to parts A (§1395c et seq.) and B (§1395j et seq.), respectively, of subchapter XVIII of chapter 7 of this title. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§1396 et seq.) and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (f)(3)(B)(ii), is section 311(b)(1)(C) of Pub. L. 111-3, which is set out as a note under section 1181 of Title 29, Labor.

CODIFICATION

Section was classified to section 300gg of this title prior to amendment and renumbering by Pub. L. 111-148.

Section 242(a)(3) of Pub. L. 112-40 amended section 2701 of act July 1, 1944, "as in effect for plan years beginning before January 1, 2014", which was classified to section 300gg of this title prior to amendment and renumbering by Pub. L. 111-148. Section 242(a)(4) of Pub. L. 112-40 made identical amendment to section 2704 of act July 1, 1944, "as in effect for plan years beginning on or after January 1, 2014", which is set out as this section. See 2011 Amendment note below. For effective date of renumbering by section 1201(2) of Pub. L. 111-148, see Effective Date of 2010 Amendment note below.

PRIOR PROVISIONS

A prior section 2704 of act July 1, 1944, was renumbered section 2725 and is classified to section 300gg-25 of this title.

Another prior section 2704 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238c of this title.

AMENDMENTS

2011—Subsec. (c)(2)(C). Pub. L. 112-40 substituted "January 1, 2014" for "February 13, 2011" in introductory provisions. See Codification note above.

2010—Pub. L. 111-148, §1201(2)(A), substituted "Prohibition of preexisting condition exclusions or other discrimination based on health status" for "Increased portability through limitation on preexisting condition exclusions" in section catchline, added subsec. (a), and struck out former subsec. (a) which related to limitation on preexisting condition exclusion period.

Subsec. (c)(2)(A), (B). Pub. L. 111-148, §1563(c)(1)(A)(i), formerly §1562(c)(1)(A)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted "group or individual health plan" for "group health plan".

³So in original. Probably should be followed by the word "Program".

Subsec. (c)(2)(C). Pub. L. 111-344 substituted “February 13, 2011” for “January 1, 2011” in introductory provisions.

Subsec. (c)(3)(A), (B). Pub. L. 111-148, § 1563(c)(1)(A)(ii)(I), formerly § 1562(c)(1)(A)(ii)(I), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “group or individual health insurance” for “group health insurance”.

Subsec. (c)(3)(D). Pub. L. 111-148, § 1563(c)(1)(A)(ii)(II), formerly § 1562(c)(1)(A)(ii)(II), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “individual or group” for “small or large” in introductory provisions.

Subsec. (d)(1) to (3). Pub. L. 111-148, § 1563(c)(1)(B), formerly § 1562(c)(1)(B), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “group or individual health insurance” for “group health insurance”.

Subsec. (e)(1)(A). Pub. L. 111-148, § 1563(c)(1)(C), formerly § 1562(c)(1)(C), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “group or individual health insurance” for “group health insurance” in introductory provisions.

2009—Subsec. (c)(2)(C). Pub. L. 111-5 added subpar. (C).
Subsec. (f)(3). Pub. L. 111-3 added par. (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112-40 applicable to plan years beginning after Feb. 12, 2011, with transitional rules, see section 242(b) of Pub. L. 112-40, set out as a note under section 9801 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111-344 applicable to plan years beginning after Dec. 31, 2010, see section 114(d) of Pub. L. 111-344, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by section 1201(2) of Pub. L. 111-148 effective for plan years beginning on or after Jan. 1, 2014, except that the provisions of this section, as they apply to enrollees who are under 19 years of age, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1255 of Pub. L. 111-148, set out as an Effective Date note under section 300gg of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided and subject to certain applicability provisions, amendment by Pub. L. 111-5 effective upon the expiration of the 90-day period beginning on Feb. 17, 2009, see section 1891 of Pub. L. 111-5, set out as an Effective Dates and Termination Dates of 2009 Amendment note under section 2271 of Title 19, Customs Duties.

Amendment by Pub. L. 111-5 applicable to plan years beginning after Feb. 17, 2009, see section 1899D(d) of Pub. L. 111-5, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 111-3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111-3, set out as an Effective Date note under section 1396 of this title.

§ 300gg-4. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (1) Health status.
- (2) Medical condition (including both physical and mental illnesses).
- (3) Claims experience.
- (4) Receipt of health care.
- (5) Medical history.
- (6) Genetic information.
- (7) Evidence of insurability (including conditions arising out of acts of domestic violence).
- (8) Disability.
- (9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and health¹ insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

¹ So in original. Probably should be preceded by “a”.

(c) Genetic testing**(1) Limitation on requesting or requiring genetic testing**

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment**(A) In general**

Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act [42 U.S.C. 1320d et seq.] and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) Limitation

For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

- (i) compliance with the request is voluntary; and
- (ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information**(1) In general**

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 300gg-91 of this title).

(2) Prohibition on collection of genetic information prior to enrollment

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans

The provisions of subsections (a)(6), (b)(3), (c), and (d) and subsection (b)(1) and section 300gg-3 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 300gg-21(a)² of this title.

(f) Genetic information of a fetus or embryo

Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(j)³ Programs of health promotion or disease prevention**(1) General provisions****(A) General rule**

For purposes of subsection (b)(2)(B), a program of health promotion or disease preven-

² See References in Text note below.

³ So in original. No subsecs. (g) to (i) have been enacted.

tion (referred to in this subsection as a “wellness program”) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

(B) No conditions based on health status factor

If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

(C) Conditions based on health status factor

If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

(2) Wellness programs not subject to requirements

If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

(A) A program that reimburses all or part of the cost for memberships in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group¹ health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

(3) Wellness programs subject to requirements

If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a

standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

(k) Existing programs

Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to March 23, 2010, and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(l) Wellness program demonstration project

(1) In general

Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

(2) Expansion of demonstration project

If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

(3) Requirements

(A) Maintenance of coverage

The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under section 36B of title 26 or cost-sharing assistance under section 18071 of this title.

(B) Other requirements

States that participate in the demonstration project under this subsection—

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for ad-

herence to, or participation in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

(I) do not create undue burdens for individuals insured in the individual market;

(II) do not lead to cost shifting; and

(III) are not a subterfuge for discrimination;

(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note); and

(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

(m) Report

(1) In general

Not later than 3 years after March 23, 2010, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

(D) the effectiveness of different types of rewards.

(2) Data collection

In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

(n) Regulations

Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

(July 1, 1944, ch. 373, title XXVII, §2705, as added and amended Pub. L. 111-148, title I, §1201(3), (4), Mar. 23, 2010, 124 Stat. 154, 156.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§1320d et seq.) of subchapter XI of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsecs. (c)(3)(A) and (l)(3)(B)(iv), is section 264 of Pub. L. 104-191, which is set out as a note under section 1320d-2 of this title.

Section 300gg-21(a) of this title, referred to in subsec. (e), was in the original a reference to section 2735(a) of act July 1, 1944, and was translated as if it referred to section 2722(a) of that act to reflect the probable intent of Congress because of the renumbering of section 2735 as 2722 by Pub. L. 111-148, title I, §1563(c)(12)(D), formerly §1562(c)(12)(D), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 269, 911. The act July 1, 1944, does not contain a section 2735.

CODIFICATION

The text of section 300gg-1 of this title, which was amended and transferred to subsecs. (b) to (f) of this section by Pub. L. 111-148, §1201(3), was based on act July 1, 1944, ch. 373, title XXVII, §2702, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1961; amended Pub. L. 110-233, title I, §102(a)(1)-(3), May 21, 2008, 122 Stat. 888, 890.

PRIOR PROVISIONS

A prior section 300gg-4, act July 1, 1944, ch. 373, title XXVII, §2704, as added Pub. L. 104-204, title VI, §604(a)(3), Sept. 26, 1996, 110 Stat. 2939, which related to standards relating to benefits for mothers and newborns, was renumbered section 2725 of act July 1, 1944, by Pub. L. 111-148, title I, §1001(2), Mar. 23, 2010, 124 Stat. 130, and transferred to section 300gg-25 of this title.

A prior section 2705 of act July 1, 1944, was renumbered section 2726 and is classified to section 300gg-26 of this title.

Another prior section 2705 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238d of this title.

AMENDMENTS

2010—Pub. L. 111-148, §1201(3), transferred section 300gg-1 of this title to subsecs. (b) to (f) of this section after amending it by striking out the section catchline “Prohibiting discrimination against individual participants and beneficiaries based on health status”, by striking subsec. (a) which prohibited discrimination against individual participants in group health plans based on certain health status-related factors, by amending subsec. (b) by substituting “health insurance issuer offering group or individual health insurance coverage” for “health insurance issuer offering health insurance coverage in connection with a group health plan” in pars. (1) and (3)(B) and by inserting “or individual” after “employer” and “or individual health coverage, as the case may be” before semicolon in par. (2)(A), and by amending subsec. (e) by substituting “(a)(6)” for “(a)(1)(F)” and “300gg-3” for “300gg” and making technical amendment to reference in original act which appears in text as reference to section 300gg-21(a) of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111-148, set out as a note under section 300gg of this title.

§ 300gg-5. Non-discrimination in health care**(a) Providers**

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

(b) Individuals

The provisions of section 218c¹ of title 29 (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

(July 1, 1944, ch. 373, title XXVII, §2706, as added Pub. L. 111-148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 160.)

Editorial Notes

REFERENCES IN TEXT

Section 218c of title 29, referred to in subsec. (b), was in the original “section 1558 of the Patient Protection and Affordable Care Act”, meaning section 1558 of Pub. L. 111-148, and was translated as meaning section 18C of act June 25, 1938, ch. 676, which was added by section 1558 of Pub. L. 111-148, to reflect the probable intent of Congress.

PRIOR PROVISIONS

A prior section 300gg-5, act July 1, 1944, ch. 373, title XXVII, §2705, as added Pub. L. 104-204, title VII, §703(a), Sept. 26, 1996, 110 Stat. 2947, and amended, which related to parity in mental health and substance use disorder benefits, was renumbered section 2726 of act July 1, 1944, and transferred to section 300gg-26 of this title.

A prior section 2706 of act July 1, 1944, was renumbered section 2727 and is classified to section 300gg-27 of this title.

Another prior section 2706 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238e of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111-148, set out as a note under section 300gg of this title.

IMPLEMENTING PROTECTIONS AGAINST PROVIDER DISCRIMINATION

Pub. L. 116-260, div. BB, title I, §108, Dec. 27, 2020, 134 Stat. 2859, provided that: “Not later than January 1, 2022, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall issue a proposed rule implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)). The Secretaries shall accept and

¹ See References in Text note below.

consider public comments on any proposed rule issued pursuant to this subsection for a period of 60 days after the date of such issuance. Not later than 6 months after the date of the conclusion of the comment period, the Secretaries shall issue a final rule implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)).”

§ 300gg-6. Comprehensive health insurance coverage

(a) Coverage for essential health benefits package

A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title.

(b) Cost-sharing under group health plans

A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraph (1) of section 18022(c)¹ of this title.

(c) Child-only plans

If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 18022(d) of this title, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

(d) Dental only

This section shall not apply to a plan described in section 18031(d)(2)(B)(ii)¹ of this title.

(July 1, 1944, ch. 373, title XXVII, § 2707, as added Pub. L. 111-148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 161; amended Pub. L. 113-93, title II, § 213(b), Apr. 1, 2014, 128 Stat. 1047.)

Editorial Notes

REFERENCES IN TEXT

Section 18022(c) of this title, referred to in subsec. (b), was in the original “section 1302(c)”, and was translated as meaning section 1302(c) of Pub. L. 111-148, par. (1) of which relates to annual limitation on cost-sharing, to reflect the probable intent of Congress.

Section 18031(d)(2)(B)(ii) of this title, referred to in subsec. (d), was in the original “section 1302(d)(2)(B)(ii)(I)”, and was translated as meaning section 1311(d)(2)(B)(ii) of Pub. L. 111-148, which relates to offering of stand-alone dental benefits, to reflect the probable intent of Congress.

PRIOR PROVISIONS

A prior section 300gg-6, act July 1, 1944, ch. 373, title XXVII, § 2706, as added Pub. L. 105-277, div. A, § 101(f) [title IX, § 903(a)], Oct. 21, 1998, 112 Stat. 2681-337, 2681-438, which related to required coverage for reconstructive surgery following mastectomies, was renumbered section 2727 of act July 1, 1944, and transferred to section 300gg-27 of this title.

A prior section 2707 of act July 1, 1944, was renumbered section 2728 and is classified to section 300gg-28 of this title.

Another prior section 2707 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238f of this title.

AMENDMENTS

2014—Subsec. (b). Pub. L. 113-93 substituted “paragraph (1)” for “paragraphs (1) and (2)”.

¹ See References in Text note below.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113-93, title II, § 213(c), Apr. 1, 2014, 128 Stat. 1047, provided that: “The amendments made by this Act [probably means this section, amending this section and section 18022 of this title] shall be effective as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111-148).”

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111-148, set out as a note under section 300gg of this title.

§ 300gg-7. Prohibition on excessive waiting periods

A group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in section 300gg-3(b)(4) of this title) that exceeds 90 days.

(July 1, 1944, ch. 373, title XXVII, § 2708, as added and amended Pub. L. 111-148, title I, § 1201(4), title X, § 10103(b), Mar. 23, 2010, 124 Stat. 161, 892.)

Editorial Notes

PRIOR PROVISIONS

A prior section 300gg-7, act July 1, 1944, ch. 373, title XXVII, § 2707, as added Pub. L. 110-381, § 2(b)(1), Oct. 9, 2008, 122 Stat. 4083, which related to coverage of dependent students on medically necessary leave of absence, was renumbered section 2728 of act July 1, 1944, and transferred to section 300gg-28 of this title.

A prior section 2708 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238g of this title.

AMENDMENTS

2010—Pub. L. 111-148, § 10103(b), struck out “or individual” after “offering group”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111-148, set out as a note under section 300gg of this title.

§ 300gg-8. Coverage for individuals participating in approved clinical trials

(a) Coverage

(1) In general

If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

(2) Routine patient costs

(A) Inclusion

For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs

include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

(B) Exclusion

For purposes of paragraph (1)(B), routine patient costs does not include—

- (i) the investigational item, device, or service, itself;
- (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) Use of in-network providers

If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) Use of out-of-network

Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

(b) Qualified individual defined

For purposes of subsection (a), the term “qualified individual” means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

- (1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.
- (2) Either—
 - (A) the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
 - (B) the participant or beneficiary provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) Limitations on coverage

This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan’s (or coverage’s) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

(d) Approved clinical trial defined

(1) In general

In this section, the term “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

(A) **FEDERALLY FUNDED TRIALS.**—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- (i) The National Institutes of Health.
- (ii) The Centers for Disease Control and Prevention.
- (iii) The Agency for Health Care Research and Quality.
- (iv) The Centers for Medicare & Medicaid Services.

(v) cooperative¹ group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following if the conditions described in paragraph (2) are met:

- (I) The Department of Veterans Affairs.
- (II) The Department of Defense.
- (III) The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(2) Conditions for departments

The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) Life-threatening condition defined

In this section, the term “life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(f) Construction

Nothing in this section shall be construed to limit a plan’s or issuer’s coverage with respect to clinical trials.

¹ So in original. Probably should be preceded by “A”.

(g) Application to FEHBP

Notwithstanding any provision of chapter 89 of title 5, this section shall apply to health plans offered under the program under such chapter.

(h) Preemption

Notwithstanding any other provision of this chapter, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section..

(July 1, 1944, ch. 373, title XXVII, § 2709, as added Pub. L. 111-148, title X, § 10103(c), Mar. 23, 2010, 124 Stat. 892.)

Editorial Notes

CODIFICATION

Another section 2709 of act July 1, 1944, is classified to section 300gg-9 of this title.

PRIOR PROVISIONS

A prior section 2709 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238h of this title.

§ 300gg-9. Disclosure of information**(a) Disclosure of information by health plan issuers**

In connection with the offering of any health insurance coverage to a small employer or an individual, a health insurance issuer—

(1) shall make a reasonable disclosure to such employer, or individual, as applicable,¹ as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

(2) upon request of such a² employer, or individual, as applicable,¹ provide such information.

(b) Information described**(1) In general**

Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a² employer, or individual, as applicable,¹ information described in this subsection is information concerning—

(A) the provisions of such coverage concerning issuer's right to change premium rates and the factors that may affect changes in premium rates; and

(B) the benefits and premiums available under all health insurance coverage for which the employer, or individual, as applicable, is qualified.

(2) Form of information

Information under this subsection shall be provided to employers, or individuals, as applicable, in a manner determined to be understandable by the average employer, or individual, as applicable,¹ and shall be sufficient to reasonably inform employers, or individuals, as applicable, of their rights and obligations under the health insurance coverage.

(3) Exception

An issuer is not required under this section to disclose any information that is proprietary

and trade secret information under applicable law.

(July 1, 1944, ch. 373, title XXVII, § 2709, formerly § 2713, as added Pub. L. 104-191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1966; renumbered § 2733, renumbered § 2709, and amended Pub. L. 111-148, title I, §§ 1001(3), 1563(c)(10), formerly § 1562(c)(10), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 268, 911.)

Editorial Notes

CODIFICATION

Section was formerly classified to section 300gg-13 of this title prior to renumbering by Pub. L. 111-148.

Another section 2709 of act July 1, 1944, is classified to section 300gg-8 of this title.

PRIOR PROVISIONS

A prior section 2709 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238h of this title.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-148, § 1563(c)(10)(A), formerly § 1562(c)(10)(A), as renumbered by Pub. L. 111-148, § 10107(b)(1), in introductory provisions substituted “small employer or an individual” for “small employer”, in par. (1) inserted “, or individual, as applicable,” after “employer”, and in par. (2) substituted “employer, or individual, as applicable,” for “small employer”.

Subsec. (b)(1). Pub. L. 111-148, § 1563(c)(10)(B)(i), formerly § 1562(c)(10)(B)(i), as renumbered by Pub. L. 111-148, § 10107(b)(1), in introductory provisions substituted “employer, or individual, as applicable,” for “small employer”, in subpar. (A), inserted “and” at end, struck out subpars. (B) and (C) which related to provisions of coverage relating to renewability of coverage and preexisting condition exclusions, respectively, in subpar. (D), inserted “, or individual, as applicable,” after “employer”, and redesignated subpar. (D) as (B).

Subsec. (b)(2). Pub. L. 111-148, § 1563(c)(10)(B)(ii), formerly § 1562(c)(10)(B)(ii), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “employer, or individual, as applicable,” for “small employer” and “employers, or individuals, as applicable,” for “small employers” in two places.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104-191, set out as a note under section 300gg of this title.

SUBPART II—IMPROVING COVERAGE

Editorial Notes

PRIOR PROVISIONS

A prior subpart 2, consisting of sections 300gg-4 to 300gg-7, related to other requirements, prior to repeal of the subpart designation and heading and transfer of sections 300gg-4 to 300gg-7 to 300gg-25 to 300gg-28, respectively, of this title by Pub. L. 111-148, title I, §§ 1001(2), 1563(c)(2), formerly § 1562(c)(2), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911.

Another prior subpart 2, consisting of sections 300gg-11 to 300gg-13, related to provisions applicable only to health insurance issuers, was redesignated subpart 3 of this part by Pub. L. 104-204, title VI, § 604(a)(2), Sept. 26, 1996, 110 Stat. 2939.

¹ So in original.

² So in original. Probably should be “an”.

A prior subpart 3, consisting of sections 300gg-11 to 300gg-13, related to provisions applicable only to health insurance issuers, prior to repeal of the subpart designation and heading by Pub. L. 111-148, title I, §1563(c)(7), formerly §1562(c)(7), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 266, 911.

A prior subpart 4, consisting of sections 300gg-21 to 300gg-23, which related to exclusion of plans, enforcement, and preemption, was redesignated subpart 2 of this part by Pub. L. 111-148, title I, §1563(c)(11), formerly §1562(c)(11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 268, 911.

§ 300gg-11. No lifetime or annual limits

(a) Prohibition

(1) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

(2) Annual limits prior to 2014

With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 18022(b) of this title, as determined by the Secretary. In defining the term “restricted annual limit” for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

(b) Per beneficiary limits

Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 18022(b) of this title, to the extent that such limits are otherwise permitted under Federal or State law.

(July 1, 1944, ch. 373, title XXVII, §2711, as added and amended Pub. L. 111-148, title I, §1001(5), title X, §10101(a), Mar. 23, 2010, 124 Stat. 131, 883.)

Editorial Notes

PRIOR PROVISIONS

A prior section 300gg-11, act July 1, 1944, ch. 373, title XXVII, §2711, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1962, which related to guaranteed availability of coverage for employers in a group market, was renumbered section 2731 of act July 1, 1944, amended, and transferred to subsecs. (c) and (d) of section 300gg-1 of this title, by Pub. L. 111-148, title I, §§1001(3), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.

Another prior section 2711 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238j of this title.

AMENDMENTS

2010—Pub. L. 111-148, §10101(a), amended section generally. Prior to amendment, text read as follows:

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

“(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

“(2) unreasonable annual limits (within the meaning of section 223 of title 26) on the dollar value of benefits for any participant or beneficiary.

“(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 18022(b) of this title from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.”

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 111-148, title I, §1004, Mar. 23, 2010, 124 Stat. 140, provided that:

“(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle [subtitle A (§§1001-1004) of title I of Pub. L. 111-148, enacting this section and sections 300gg-12 to 300gg-15, 300gg-16 to 300gg-19, 300gg-93, and 300gg-94 of this title, amending former sections 300gg-11 and 300gg-12 of this title and sections 300gg-21 to 300gg-23 of this title, and transferring section 300gg-13 of this title to section 300gg-9 of this title and sections 300gg-4 to 300gg-7 of this title to sections 300gg-25 to 300gg-28 of this title, respectively] (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act [Mar. 23, 2010], except that the amendments made by sections 1002 and 1003 [enacting sections 300gg-93 and 300gg-94 of this title] shall become effective for fiscal years beginning with fiscal year 2010.

“(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 [enacting sections 300gg-93 and 300gg-94 of this title] shall take effect on the date of enactment of this Act [Mar. 23, 2010].”

§ 300gg-12. Prohibition on rescissions

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 300gg-2(b)¹ or 300gg-42(b) of this title.

(July 1, 1944, ch. 373, title XXVII, §2712, as added Pub. L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131.)

Editorial Notes

REFERENCES IN TEXT

Section 300gg-2(b) of this title, referred to in text, was in the original a reference to section “2702(c)” of act July 1, 1944, which was translated as meaning section 2703(b) of act July 1, 1944, to reflect the probable intent of Congress. Section 2702(c), which is classified to section 300gg-1 of this title, relates to special rules for network plans, while section 2703(b) specifies the

¹ See References in Text note below.

reasons for which a health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offering in the group or individual market. Section 300gg-2(b) also parallels section 300gg-42(b) which appears in the same context in this section as the reference to section 300gg-2(b).

PRIOR PROVISIONS

A prior section 300gg-12, act July 1, 1944, ch. 373, title XXVII, §2712, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1964, which related to guaranteed renewability of coverage for employers in a group market, was renumbered section 2732 of act July 1, 1944, amended, and transferred to subsecs. (b) to (e) of section 300gg-2 of this title, by Pub. L. 111-148, title I, §§1001(3), 1563(c)(9), formerly §1562(c)(9), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 267, 911.

Another prior section 2712 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238k of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-13. Coverage of preventive health services

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and¹

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.²

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.²

(5) for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those rec-

ommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

(b) Interval

(1) In general

The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

(2) Minimum

The interval described in paragraph (1) shall not be less than 1 year.

(c) Value-based insurance design

The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

(July 1, 1944, ch. 373, title XXVII, §2713, as added Pub. L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131.)

Editorial Notes

PRIOR PROVISIONS

A prior section 300gg-13, act July 1, 1944, ch. 373, title XXVII, §2713, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1966, was renumbered section 2709 of act July 1, 1944, and transferred to section 300gg-9 of this title by Pub. L. 111-148, title I, §§1001(3), 1563(c)(10)(C), formerly §1562(c)(10)(C), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 268, 911.

Another prior section 2713 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238l of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

RAPID COVERAGE OF PREVENTIVE SERVICES AND VACCINES FOR CORONAVIRUS

Pub. L. 116-136, div. A, title III, §3203, Mar. 27, 2020, 134 Stat. 367, provided that:

“(a) IN GENERAL.—Notwithstanding [section] 2713(b) of the Public Health Service Act (42 U.S.C. 300gg-13[(b)]), the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall require group health plans and health insurance issuers offering group or individual health insurance to cover (without cost-sharing) any qualifying coronavirus preventive service, pursuant to section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg-13(a)) (including the regulations under sections 2590.715-2713 of title 29, Code of Federal Regulations, section 54.9815-2713 of title 26, Code of Federal Regulations, and section 147.130 of title 45, Code of Federal Regulations (or any successor regulations)). The requirement described in this subsection shall take effect with respect to a qualifying coronavirus preventive service on the specified date described in subsection (b)(2).

“(b) DEFINITIONS.—For purposes of this section:

“(1) QUALIFYING CORONAVIRUS PREVENTIVE SERVICE.—The term ‘qualifying coronavirus preventive

¹ So in original. The word “and” probably should not appear.

² So in original. The period probably should be a semicolon.

service' means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is—

“(A) an evidence-based item or service that has in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force; or

“(B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

“(2) SPECIFIED DATE.—The term ‘specified date’ means the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service as described in such paragraph.

“(3) ADDITIONAL TERMS.—In this section, the terms ‘group health plan’, ‘health insurance issuer’, ‘group health insurance coverage’, and ‘individual health insurance coverage’ have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code [26 U.S.C. 9832], as applicable.”

§ 300gg-14. Extension of dependent coverage

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

(b) Regulations

The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

(c) Rule of construction

Nothing in this section shall be construed to modify the definition of “dependent” as used in title 26 with respect to the tax treatment of the cost of coverage.

(July 1, 1944, ch. 373, title XXVII, § 2714, as added Pub. L. 111-148, title I, § 1001(5), Mar. 23, 2010, 124 Stat. 132; amended Pub. L. 111-152, title II, § 2301(b), Mar. 30, 2010, 124 Stat. 1082.)

Editorial Notes

PRIOR PROVISIONS

A prior section 2714 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238m of this title.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-152 struck out “(who is not married)” after “adult child”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-15. Development and utilization of uniform explanation of coverage documents and standardized definitions

(a) In general

Not later than 12 months after March 23, 2010, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the “NAIC”), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) Requirements

The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

(1) Appearance

The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) Language

The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) Contents

The standards shall ensure that the summary of benefits and coverage includes—

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost sharing for—

(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 18022(b)(1) of this title; and

(ii) other benefits, as identified by the Secretary;

(C) the exceptions, reductions, and limitations on coverage;

(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

(E) the renewability and continuation of coverage provisions;

(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost

sharing, such scenarios to be based on recognized clinical practice guidelines;

(G) a statement of whether the plan or coverage—

(i) provides minimum essential coverage (as defined under section 5000A(f) of title 26); and

(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

(c) Periodic review and updating

The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

(d) Requirement to provide

(1) In general

Not later than 24 months after March 23, 2010, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

(A) an applicant at the time of application;

(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(2) Compliance

An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

(3) Entities in general

An entity described in this paragraph is—

(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 1002(16) of title 29).

(4) Notice of modifications

If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 1022 of title 29) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

(e) Preemption

The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

(f) Failure to provide

An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

(g) Development of standard definitions

(1) In general

The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

(2) Insurance-related terms

The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(3) Medical terms

The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

(July 1, 1944, ch. 373, title XXVII, §2715, as added and amended Pub. L. 111-148, title I, §1001(5), title X, §10101(b), Mar. 23, 2010, 124 Stat. 132, 884.)

Editorial Notes

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-148, §10101(b), substituted “and providing to applicants, enrollees, and policyholders or certificate holders” for “and providing to enrollees”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-15a. Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

(July 1, 1944, ch. 373, title XXVII, §2715A, as added Pub. L. 111-148, title X, §10101(c), Mar. 23, 2010, 124 Stat. 884.)

§ 300gg-16. Prohibition on discrimination in favor of highly compensated individuals**(a) In general**

A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of title 26 (relating to prohibition on discrimination in favor of highly compensated individuals).

(b) Rules and definitions

For purposes of this section—

(1) Certain rules to apply

Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of title 26 shall apply.

(2) Highly compensated individual

The term “highly compensated individual” has the meaning given such term by section 105(h)(5) of title 26.

(July 1, 1944, ch. 373, title XXVII, §2716, as added and amended Pub. L. 111-148, title I, §1001(5), title X, §10101(d), Mar. 23, 2010, 124 Stat. 135, 884.)

Editorial Notes**AMENDMENTS**

2010—Pub. L. 111-148, §10101(d), amended section generally. Prior to amendment, text read as follows:

“(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

“(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.”

Statutory Notes and Related Subsidiaries**EFFECTIVE DATE**

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-17. Ensuring the quality of care**(a) Quality reporting****(1) In general**

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in

health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602¹ of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) Reporting requirements**(A) In general**

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) Timing of reports

A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

(C) Availability of reports

The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

(D) Penalties

In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

(E) Exceptions

In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

(b) Wellness and prevention programs

For purposes of subsection (a)(1)(D), wellness and health promotion activities may include

¹ See References in Text note below.

personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

- (1) Smoking cessation.
- (2) Weight management.
- (3) Stress management.
- (4) Physical fitness.
- (5) Nutrition.
- (6) Heart disease prevention.
- (7) Healthy lifestyle support.
- (8) Diabetes prevention.

(c) Protection of Second Amendment gun rights

(1) Wellness and prevention programs

A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

- (A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or
- (B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

(2) Limitation on data collection

None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

- (A) the lawful ownership or possession of a firearm or ammunition;
- (B) the lawful use of a firearm or ammunition; or
- (C) the lawful storage of a firearm or ammunition.

(3) Limitation on databases or data banks

None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) Limitation on determination of premium rates or eligibility for health insurance

A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

- (A) the lawful ownership or possession of a firearm or ammunition; or
- (B) the lawful use or storage of a firearm or ammunition.

(5) Limitation on data collection requirements for individuals

No individual shall be required to disclose any information under any data collection ac-

tivity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

- (A) the lawful ownership or possession of a firearm or ammunition; or
- (B) the lawful use, possession, or storage of a firearm or ammunition.

(d) Regulations

Not later than 2 years after March 23, 2010, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

(e) Study and report

Not later than 180 days after the date on which regulations are promulgated under subsection (c),² the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

(July 1, 1944, ch. 373, title XXVII, §2717, as added and amended Pub. L. 111-148, title I, §1001(5), title X, §10101(e), Mar. 23, 2010, 124 Stat. 135, 884.)

Editorial Notes

REFERENCES IN TEXT

Section 3602 of the Patient Protection and Affordable Care Act, referred to in subsec. (a)(1)(A), is section 3602 of Pub. L. 111-148 which is set out as a note under section 1305w-21 of this title but the reference probably should be to section 3502 of the Act which is set out as a note under section 256a-1 of this title.

The Patient Protection and Affordable Care Act, referred to in subsec. (c), is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

AMENDMENTS

2010—Subsecs. (c) to (e). Pub. L. 111-148, §10101(e), added subsec. (c) and redesignated former subsecs. (c) and (d) as (d) and (e), respectively.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-18. Bringing down the cost of health care coverage

(a) Clear accounting for costs

A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for

² So in original. Probably should be "subsection (d),".

collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

- (1) on reimbursement for clinical services provided to enrollees under such coverage;
- (2) for activities that improve health care quality; and
- (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

(b) Ensuring that consumers receive value for their premium payments

(1) Requirement to provide value for premium payments

(A) Requirement

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

- (i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or
- (ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

(B) Rebate amount

(i) Calculation of amount

The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

- (I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and
- (II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections

18061, 18062, and 18063 of this title) for such plan year.

(ii) Calculation based on average ratio

Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

(2) Consideration in setting percentages

In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

(3) Enforcement

The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

(c) Definitions

Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) Adjustments

The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

(e) Standard hospital charges

Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

(July 1, 1944, ch. 373, title XXVII, §2718, as added and amended Pub. L. 111-148, title I, §1001(5), title X, §10101(f), Mar. 23, 2010, 124 Stat. 136, 885.)

Editorial Notes

AMENDMENTS

2010—Pub. L. 111-148, §10101(f), amended section generally. Prior to amendment, the section related to clear accounting for costs, ensuring that consumers receive value for premiums, standard hospital charges, and definitions.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section

1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-19. Appeals process

(a) Internal claims appeals

(1) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

(A) have in effect an internal claims appeal process;

(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 300gg-93 of this title to assist such enrollees with the appeals processes; and

(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

(2) Established processes

To comply with paragraph (1)—

(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on March 23, 2010), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

(b) External review

A group health plan and a health insurance issuer offering group or individual health insurance coverage—

(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

(c) Secretary authority

The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

(July 1, 1944, ch. 373, title XXVII, § 2719, as added and amended Pub. L. 111-148, title I, § 1001(5), title X, § 10101(g), Mar. 23, 2010, 124 Stat. 137, 887.)

Editorial Notes

AMENDMENTS

2010—Pub. L. 111-148, § 10101(g), amended section generally. Prior to amendment, section related to implementation of appeals process by group health plans and health insurance issuers.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS

Pub. L. 116-260, div. BB, title I, § 110, Dec. 27, 2020, 134 Stat. 2861, provided that:

“(a) IN GENERAL.—In applying the provisions of section 2719(b) of the Public Health Service Act (42 U.S.C. 300gg-19(b)) to group health plans and health insurance issuers offering group or individual health insurance coverage, the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury, shall require, beginning not later than January 1, 2022, the external review process described in paragraph (1) of such section to apply with respect to any adverse determination by such a plan or issuer under section 2799A-1 or 2799A-2 [probably means section 2799A-1 or 2799A-2 of the Public Health Service Act, 42 U.S.C. 300gg-111, 300gg-112], section 716 or 717 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1185e, 1185f], or section 9816 or 9817 of the Internal Revenue Code of 1986 [26 U.S.C. 9816, 9817], including with respect to whether an item or service that is the subject to such a determination is an item or service to which such respective section applies.

“(b) DEFINITIONS.—The terms ‘group health plan’, ‘health insurance issuer’, ‘group health insurance coverage’, and ‘individual health insurance coverage’ have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the Employee Retirement Income Security Act (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code [26 U.S.C. 9832], as applicable.”

§ 300gg-19a. Patient protections

(a) Choice of health care professional

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of

a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance issuer,¹ provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii) (I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;²

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701³ of this Act, section 1181 of title 29, or section 9801 of title 26, and other than applicable cost-sharing).

(2) Definitions

In this subsection:

(A) Emergency medical condition

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1395dd(e)(1)(A) of this title.

(B) Emergency services

The term “emergency services” means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1395dd of this title) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1395dd of this title to stabilize the patient.

(C) Stabilize

The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give⁴ in section 1395dd(e)(3) of this title.

(c) Access to pediatric care

(1) Pediatric care

In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

(2) Construction

Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(d) Patient access to obstetrical and gynecological care

(1) General rights

(A) Direct access

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) Obstetrical and gynecological care

A group health plan or health insurance issuer described in paragraph (2) shall treat

¹ So in original. Probably should be “coverage.”

² So in original. The word “and” probably should appear.

³ See References in Text note below.

⁴ So in original. Probably should be “given”.

the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) Application of paragraph

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) Construction

Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(e) Application

The provisions of this section shall not apply with respect to a group health plan, health insurance issuers, or group or individual health insurance coverage with respect to plan years beginning on or on⁵ January 1, 2022.

(July 1, 1944, ch. 373, title XXVII, §2719A, as added Pub. L. 111-148, title X, §10101(h), Mar. 23, 2010, 124 Stat. 888; amended Pub. L. 116-260, div. BB, title I, §102(a)(3)(A), Dec. 27, 2020, 134 Stat. 2771.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 102(a)(3)(A) of div. BB of Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022. See 2020 Amendment note below.

Editorial Notes

REFERENCES IN TEXT

Section 2701 of this Act, referred to in subsec. (b)(1)(D), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

⁵ So in original.

CODIFICATION

Pub. L. 111-148, which directed amendment of subpart II of part A of “title XVIII” of act July 1, 1944, by inserting section 2719A after section 2719, was executed by making the insertion in subpart II of part A of title XXVII of the Act, to reflect the probable intent of Congress.

AMENDMENTS

2020—Subsec. (e). Pub. L. 116-260 added subsec. (e).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116-260, set out as a note under section 8902 of Title 5, Government Organization and Employees.

§ 300gg-19b. Information on prescription drugs

(a) In general

A group health plan or a health insurance issuer offering group or individual health insurance coverage shall—

(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the plan or coverage from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee’s out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage; and

(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee’s out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

(b) Definition

For purposes of this section, the term “out-of-pocket cost”, with respect to acquisition of a drug, means the amount to be paid by the enrollee under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.

(July 1, 1944, ch. 373, title XXVII, §2729, as added Pub. L. 115-263, §2, Oct. 10, 2018, 132 Stat. 3672.)

SUBPART 2—EXCLUSION OF PLANS;
ENFORCEMENT; PREEMPTION

Editorial Notes

CODIFICATION

This subpart 2 designation and heading was transferred along with sections 300gg-21 to 300gg-23 of this title to appear before section 300gg-25 of this title to reflect the renumbering of the sections in the original

act by Pub. L. 111-148, title I, §§1001(4), 1563(c)(12)(D), (13)(C), (14)(B), formerly §1562(c)(12)(D), (13)(C), (14)(B), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

Pub. L. 111-148, title I, §1563(c)(11), formerly §1562(c)(11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 268, 911, redesignated subpart 4 as subpart 2.

Pub. L. 104-204, title VI, §604(a)(2), Sept. 26, 1996, 110 Stat. 2939, redesignated subpart 3 as 4.

§ 300gg-21. Exclusion of certain plans

(a) Limitation on application of provisions relating to group health plans

(1) In general

The requirements of subparts 1 and 2¹ and part D shall apply with respect to group health plans only—

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) Treatment of non-Federal governmental plans

(A) Election to be excluded

Except as provided in subparagraph (D) or (E), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2¹ otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) Period of election

An election under subparagraph (A) shall apply—

- (i) for a single specified plan year, or
- (ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

(C) Notice to enrollees

Under such an election, the plan shall provide for—

- (i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and
- (ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).¹

(D) Election not applicable to requirements concerning genetic information

The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F), (b)(3), (c),

and (d) of section 2702¹ and the provisions of sections 2701¹ and 2702(b)¹ to the extent that such provisions apply to genetic information.

(E) Election not applicable

The election described in subparagraph (A) shall not be available with respect to the provisions of subparts I and II.

(b) Exception for certain benefits

The requirements of subparts 1 and 2¹ and part D shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg-91(c)(1) of this title.

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of subparts 1 and 2¹ and part D shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(2) of this title if the benefits—

- (A) are provided under a separate policy, certificate, or contract of insurance; or
- (B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of subparts 1 and 2¹ and part D shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(3) of this title if all of the following conditions are met:

- (A) The benefits are provided under a separate policy, certificate, or contract of insurance.
- (B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.
- (C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

(3) Supplemental excepted benefits

The requirements of this part and part D shall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg-91(c)(4)¹ of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Treatment of partnerships

For purposes of this part and part D—

(1) Treatment as a group health plan

Any plan, fund, or program which would not be (but for this subsection) an employee wel-

¹ See References in Text note below.

fare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) Employer

In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner.

(3) Participants of group health plans

In the case of a group health plan, the term “participant” also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual’s beneficiaries may be eligible to receive any such benefit.

(July 1, 1944, ch. 373, title XXVII, §2722, formerly §2721, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1967; amended Pub. L. 104-204, title VI, §604(b)(1), Sept. 26, 1996, 110 Stat. 2940; Pub. L. 110-233, title I, §102(c), May 21, 2008, 122 Stat. 895; renumbered §2735, renumbered §2722, and amended Pub. L. 111-148, title I, §§1001(4), 1563(a), (c)(12), formerly §1562(a), (c)(12), title X, §10107(a), (b)(1), Mar. 23, 2010, 124 Stat. 130, 264, 268, 911; Pub. L. 116-260, div. BB, title I, §102(a)(3)(B), Dec. 27, 2020, 134 Stat. 2772.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 102(a)(3)(B) of div. BB of Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022. See 2020 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

Subparts 1 and 2, referred to in subsecs. (a)(1), (2)(A), (b), and (c)(1), (2), were amended by Pub. L. 111-148, title I, §§1001(5), 1201(1), 1563(c)(2), (11), formerly §1562(c)(2), (11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 154, 265, 268, 911. The subpart 1 designation and heading “PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS” were struck out and a new subpart I designation and heading “GENERAL REFORM” were enacted preceding section 300gg of this title, effective for plan years beginning on or after Jan. 1, 2014. A new subpart II designation and heading “IMPROVING COVERAGE” were enacted preceding section 300gg-11 of this title. The subpart 2 designation and heading “OTHER REQUIREMENTS” were struck out preceding section 300gg-4 of this title, and subpart 4 was redesignated as subpart 2 “EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION” preceding section 300gg-21 of this title.

Section 2701, referred to in subsec. (a)(2)(C)(ii), (D), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title,

was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 2702, referred to in subsec. (a)(2)(D), is a reference to section 2702 of act July 1, 1944. Section 2702, which was classified to section 300gg-1 of this title, was amended by Pub. L. 111-148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg-4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111-148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg-1 of this title.

Section 300gg-91(c)(4) of this title, referred to in subsec. (c)(3), was in the original “section 27971(c)(4)” and was translated as reading “section 2791(c)(4)”, meaning section 2791(c)(4) of act July 1, 1944, as added by Pub. L. 104-191, §102(a), to reflect the probable intent of Congress. Act July 1, 1944, does not contain a section 27971.

PRIOR PROVISIONS

A prior section 2722 of act July 1, 1944, was renumbered section 2723 and is classified to section 300gg-22 of this title.

AMENDMENTS

2020—Subsecs. (a)(1), (b), (c)(1), (2). Pub. L. 116-260, §102(a)(3)(B)(i)–(iv), inserted “and part D” after “subparts 1 and 2” in introductory provisions of subsecs. (a)(1) and (c)(1), (2) and in subsec. (b).

Subsecs. (c)(3), (d). Pub. L. 116-260, §102(a)(3)(B)(v), (vi), inserted “and part D” after “this part”.

2010—Pub. L. 111-148, §1563(c)(12)(B), formerly §1562(c)(12)(B), as renumbered by Pub. L. 111-148, §10107(b)(1), which directed amendment of section by substituting “subpart 1” for “subparts 1 through 3” wherever appearing, could not be executed because the words “subparts 1 through 3” did not appear subsequent to amendments by section 1563(a)(2)(A), (B)(ii), (3), (4)(A), (B)(i) of Pub. L. 111-148. See below.

Subsec. (a). Pub. L. 111-148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111-148, §10107(b)(1), redesignated subsec. (b) as (a).

Pub. L. 111-148, §§1563(a)(1) and 1563(c)(12)(A), formerly §§1562(a)(1) and 1562(c)(12)(A), as renumbered by Pub. L. 111-148, §10107(b)(1), made identical amendment, striking out subsec. (a). Prior to amendment, text read as follows: “The requirements of subparts 1 and 3 shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.”

Subsec. (b). Pub. L. 111-148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111-148, §10107(b)(1), redesignated subsec. (c) as (b). Former subsec. (b) redesignated (a).

Pub. L. 111-148, §1563(a)(2)(A), formerly §1562(a)(2)(A), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “subparts 1 and 2” for “subparts 1 through 3” in introductory provisions.

Pub. L. 111-148, §1563(a)(2)(B)(ii), formerly §1562(a)(2)(B)(ii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “subparts 1 and 2” for “subparts 1 through 3”.

Pub. L. 111-148, §1563(a)(2)(B)(i), formerly §1562(a)(2)(B)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “subparagraph (D) or (E)” for “subparagraph (D)”.

Subsec. (b)(2)(E). Pub. L. 111–148, §10107(a), substituted “subparts I and II” for “subpart 1”.

Pub. L. 111–148, §1563(a)(2)(B)(iii), formerly §1562(a)(2)(B)(iii), as renumbered by Pub. L. 111–148, §10107(b)(1), added subpar. (E).

Subsec. (c). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (d) as (c). Former subsec. (c) redesignated (b).

Pub. L. 111–148, §1563(a)(3), formerly §1562(a)(3), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted “subparts 1 and 2 shall not apply to any individual coverage or any group” for “subparts 1 through 3 shall not apply to any group”.

Subsec. (d). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (e) as (d). Former subsec. (d) redesignated (c).

Pub. L. 111–148, §1563(a)(4)(A), formerly §1562(a)(4)(A), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted “subparts 1 and 2 shall not apply to any individual coverage or any group” for “subparts 1 through 3 shall not apply to any group” in introductory provisions.

Pub. L. 111–148, §1563(a)(4)(B)(i), formerly §1562(a)(4)(B)(i), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted “subparts 1 and 2 shall not apply to any individual coverage or any group” for “subparts 1 through 3 shall not apply to any group” in introductory provisions.

Subsec. (d)(2)(C). Pub. L. 111–148, §1563(a)(4)(B)(ii), formerly §1562(a)(4)(B)(ii), as renumbered by Pub. L. 111–148, §10107(b)(1), which directed amendment of subpar. (C) by inserting “or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer” without language specifying placement, was executed by making the insertion before period at end to reflect the probable intent of Congress.

Subsec. (d)(3). Pub. L. 111–148, §1563(a)(4)(C), formerly §1562(a)(4)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted “any individual coverage or any group” for “any group”.

Subsec. (e). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (e) as (d).

2008—Subsec. (b)(2)(A). Pub. L. 110–233, §102(c)(1), substituted “Except as provided in subparagraph (D), if the plan sponsor” for “If the plan sponsor”.

Subsec. (b)(2)(D). Pub. L. 110–233, §102(c)(2), added subpar. (D).

1996—Subsec. (a). Pub. L. 104–204, §604(b)(1)(A), substituted “subparts 1 and 3” for “subparts 1 and 2”.

Subsec. (b) to (d). Pub. L. 104–204, §604(b)(1)(B), substituted “subparts 1 through 3” for “subparts 1 and 2” wherever appearing.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116–260, set out as a note under section 8902 of Title 5, Government Organization and Employees.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–233, title I, §102(d)(2), May 21, 2008, 122 Stat. 895, provided that: “The amendments made by this section [enacting section 300gg–53 of this title and amending this section and sections 300gg–1, 300gg–22, 300gg–61, and 300gg–91 of this title] shall apply—

“(A) with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is 1 year after the date of enactment of this Act [May 21, 2008]; and

“(B) with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in

the individual market after the date that is 1 year after the date of enactment of this Act.”

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 604(c) of Pub. L. 104–204 set out as an Effective Date note under section 300gg–25 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104–191, set out as a note under section 300gg of this title.

REGULATIONS

Pub. L. 110–233, title I, §102(d)(1), May 21, 2008, 122 Stat. 895, provided that: “Not later than 12 months after the date of enactment of this Act [May 21, 2008], the Secretary of Health and Human Services shall issue final regulations to carry out the amendments made by this section [see Effective Date of 2008 Amendment note above].”

ASSURING COORDINATION

Pub. L. 110–233, title I, §106, May 21, 2008, 122 Stat. 905, provided that: “Except as provided in section 105(b)(1) [42 U.S.C. 1320d–9 note], the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

“(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this title [enacting sections 300gg–53 and 1320d–9 of this title and section 9834 of Title 26, Internal Revenue Code, amending this section, sections 300gg–1, 300gg–22, 300gg–61, 300gg–91, and 1395ss of this title, sections 9802 and 9832 of Title 26, and sections 1132, 1182, and 1191b of Title 29, Labor, and enacting provisions set out as notes under this section, sections 1320d–9 and 1395ss of this title, section 9802 of Title 26, and section 1132 of Title 29] (and the amendments made by this title) are administered so as to have the same effect at all times; and

“(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.”

§ 300gg–22. Enforcement

(a) State enforcement

(1) State authority

Subject to section 300gg–23¹ of this title, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part and part D with respect to such issuers.

(2) Failure to implement provisions

In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part or part D with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under sub-

¹ See References in Text note below.

section (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State.

(b) Secretarial enforcement authority

(1) Limitation

The provisions of this subsection shall apply to enforcement of a provision (or provisions) of this part or part D only—

- (A) as provided under subsection (a)(2); and
- (B) with respect to individual health insurance coverage or group health plans that are non-Federal governmental plans.

(2) Imposition of penalties

In the cases described in paragraph (1)—

(A) In general

Subject to the succeeding provisions of this subsection, any non-Federal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part or part D applicable to such plan or issuer is subject to a civil money penalty under this subsection.

(B) Liability for penalty

In the case of a failure by—

- (i) a health insurance issuer, the issuer is liable for such penalty, or
- (ii) a group health plan that is a non-Federal governmental plan which is—
 - (I) sponsored by 2 or more employers, the plan is liable for such penalty, or
 - (II) not so sponsored, the employer is liable for such penalty.

(C) Amount of penalty

(i) In general

The maximum amount of penalty imposed under this paragraph is \$100 for each day for each individual with respect to which such a failure occurs.

(ii) Considerations in imposition

In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this part and part D and the gravity of the violation.

(iii) Limitations

(I) Penalty not to apply where failure not discovered exercising reasonable diligence

No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) Penalty not to apply to failures corrected within 30 days

No civil money penalty shall be imposed under this paragraph on any fail-

ure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) Administrative review

(i) Opportunity for hearing

The entity assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) Hearing procedure

If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (E).

(E) Judicial review

(i) Filing of action for review

Any entity against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

(ii) Certification of administrative record

The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) Standard for review

The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5.

(iv) Appeal

Any final decision, order, or judgment of the district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28.

(F) Failure to pay assessment; maintenance of action

(i) Failure to pay assessment

If any entity fails to pay an assessment after it has become a final and

unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) Nonreviewability

In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) Payment of penalties

Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(3) Enforcement authority relating to genetic discrimination

(A) General rule

In the cases described in paragraph (1), notwithstanding the provisions of paragraph (2)(C), the succeeding subparagraphs of this paragraph shall apply with respect to an action under this subsection by the Secretary with respect to any failure of a health insurance issuer in connection with a group health plan, to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 2702¹ or section 2701¹ or 2702(b)(1)¹ with respect to genetic information in connection with the plan.

(B) Amount

(i) In general

The amount of the penalty imposed under this paragraph shall be \$100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) Noncompliance period

For purposes of this paragraph, the term “noncompliance period” means, with respect to any failure, the period—

- (I) beginning on the date such failure first occurs; and
- (II) ending on the date the failure is corrected.

(C) Minimum penalties where failure discovered

Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) In general

In the case of 1 or more failures with respect to an individual—

- (I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and
- (II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such individual shall not be less than \$2,500.

(ii) Higher minimum penalty where violations are more than de minimis

To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting “\$15,000” for “\$2,500” with respect to such person.

(D) Limitations

(i) Penalty not to apply where failure not discovered exercising reasonable diligence

No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) Penalty not to apply to failures corrected within certain periods

No penalty shall be imposed by subparagraph (A) on any failure if—

- (I) such failure was due to reasonable cause and not to willful neglect; and
- (II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) Overall limitation for unintentional failures

In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

- (I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans; or
- (II) \$500,000.

(E) Waiver by Secretary

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(July 1, 1944, ch. 373, title XXVII, § 2723, formerly § 2722, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1968; amended Pub. L. 110–233, title I, § 102(a)(5), May 21, 2008, 122 Stat. 891; renumbered § 2736, renumbered § 2723, and amended Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(13), formerly § 1562(c)(13), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911; Pub. L. 116–260, div. BB, title I, § 102(a)(3)(C), Dec. 27, 2020, 134 Stat. 2772.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 102(a)(3)(C) of div. BB of Pub. L. 116–260 applicable with respect to plan years beginning on or after Jan. 1, 2022. See 2020 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

Section 300gg-23 of this title, referred to in subsec. (a)(1), was in the original section “2723”, and was translated as meaning section 2724 of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111-148, title I, §§1001(4), 1563(c)(14)(B), formerly §1562(c)(14)(B), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

Section 2702, referred to in subsec. (b)(3)(A), is a reference to section 2702 of act July 1, 1944. Section 2702, which was classified to section 300gg-1 of this title, was amended by Pub. L. 111-148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg-4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702, related to guaranteed availability of coverage, was added by Pub. L. 111-148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg-1 of this title.

Section 2701, referred to in subsec. (b)(3)(A), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

PRIOR PROVISIONS

A prior section 2723 of act July 1, 1944, was renumbered section 2724 and is classified to section 300gg-23 of this title.

AMENDMENTS

2020—Subsec. (a)(1). Pub. L. 116-260, §102(a)(3)(C)(i), inserted “and part D” after “this part”.

Subsecs. (a)(2), (b)(1), (2)(A). Pub. L. 116-260, §102(a)(3)(C)(ii)-(iv), inserted “or part D” after “this part”.

Subsec. (b)(2)(C)(ii). Pub. L. 116-260, §102(a)(3)(C)(v), inserted “and part D” after “this part”.

2010—Subsec. (a)(1). Pub. L. 111-148, §1563(c)(13)(A)(i), formerly §1562(c)(13)(A)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual or group market” for “small or large group markets”.

Subsec. (a)(2). Pub. L. 111-148, §1563(c)(13)(a)(ii), formerly §1562(c)(13)(A)(ii), as renumbered by Pub. L. 111-148, §10107(b)(1), inserted “or individual health insurance coverage” after “group health plans”.

Subsec. (b)(1)(B). Pub. L. 111-148, §1563(c)(13)(B), formerly §1562(c)(13)(B), as renumbered by Pub. L. 111-148, §10107(b)(1), inserted “individual health insurance coverage or” after “with respect to”.

2008—Subsec. (b)(3). Pub. L. 110-233 added par. (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116-260, set out as a note under section 8902 of Title 5, Government Organization and Employees.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110-233 applicable, with respect to group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is one year

after May 21, 2008, and, with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market, after the date that is one year after May 21, 2008, see section 102(d)(2) of Pub. L. 110-233, set out as a note under section 300gg-21 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104-191, set out as a note under section 300gg of this title.

§ 300gg-23. Preemption; State flexibility; construction**(a) Continued applicability of State law with respect to health insurance issuers****(1) In general**

Subject to paragraph (2) and except as provided in subsection (b), this part, part D, and part C insofar as it relates to this part or part D shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part or part D.

(2) Continued preemption with respect to group health plans

Nothing in this part or part D shall be construed to affect or modify the provisions of section 1144 of title 29 with respect to group health plans.

(b) Special rules in case of portability requirements**(1) In general**

Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701¹ which differs from the standards or requirements specified in such section.

(2) Exceptions

Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) substitutes for the reference to “6-month period” in section 2701(a)(1)¹ a reference to any shorter period of time;

(ii) substitutes for the reference to “12 months” and “18 months” in section 2701(a)(2)¹ a reference to any shorter period of time;

(iii) substitutes for the references to “63” days in sections 2701(c)(2)(A)¹ and 2701(d)(4)(A)¹ a reference to any greater number of days;

¹ See References in Text note below.

(iv) substitutes for the reference to “30-day period” in sections 2701(b)(2)¹ and 2701(d)(1)¹ a reference to any greater period;

(v) prohibits the imposition of any pre-existing condition exclusion in cases not described in section 2701(d)¹ or expands the exceptions described in such section;

(vi) requires special enrollment periods in addition to those required under section 2701(f)¹; or

(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B)¹.

(c) Rules of construction

Nothing in this part (other than section 2704)¹ or part D shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) Definitions

For purposes of this section—

(1) State law

The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) State

The term “State” includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(July 1, 1944, ch. 373, title XXVII, §2724, formerly §2723, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1971; amended Pub. L. 104-204, title VI, §604(b)(2), Sept. 26, 1996, 110 Stat. 2941; renumbered §2737, renumbered §2724, and amended Pub. L. 111-148, title I, §§1001(4), 1563(c)(14), formerly §1562(c)(14), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911; Pub. L. 116-260, div. BB, title I, §102(a)(3)(D), Dec. 27, 2020, 134 Stat. 2772.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 102(a)(3)(D) of div. BB of Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022. See 2020 Amendment notes below.

Editorial Notes

REFERENCES IN TEXT

Section 2701, referred to in subsec. (b), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 701, referred to in subsec. (b)(1), probably means “section 2701” of act July 1, 1944. See note above.

Section 2704, referred to in subsec. (c), is a reference to section 2704 of act July 1, 1944. Section 2704, which was classified to section 300gg-4 of this title, was renumbered section 2725, and amended by Pub. L. 111-148, title I, §§1001(2), 1563(c)(3), formerly §1562(c)(3), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911, and was transferred to section 300gg-25 of this title. A new section 2704 of act July 1, 1944, related to prohibition of preexisting condition exclusions or other discrimination based on health status, was added, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and is classified to section 300gg-3 of this title.

AMENDMENTS

2020—Subsec. (a)(1). Pub. L. 116-260, §102(a)(3)(D)(i), substituted “this part, part D, and part C insofar as it relates to this part or part D” for “this part and part C insofar as it relates to this part” and inserted “or part D” before period at end.

Subsec. (a)(2). Pub. L. 116-260, §102(a)(3)(D)(ii), inserted “or part D” after “this part”.

Subsec. (c). Pub. L. 116-260, §102(a)(3)(D)(iii), inserted “or part D” after “this part (other than section 2704)”.

2010—Subsec. (a)(1). Pub. L. 111-148, §1563(c)(14)(A), formerly §1562(c)(14)(A), as renumbered by Pub. L. 111-148, §10107(b)(1), inserted “individual or” before “group health insurance”.

1996—Subsec. (c). Pub. L. 104-204 inserted “(other than section 2704)” after “part”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116-260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116-260, set out as a note under section 8902 of Title 5, Government Organization and Employees.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104-204 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 604(c) of Pub. L. 104-204 set out as an Effective Date note under section 300gg-25 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104-191, set out as a note under section 300gg of this title.

§ 300gg-25. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) Exception

Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) Prohibitions

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) Rules of construction

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan, or any health insurance issuer offering group or individual health insurance coverage, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) Notice

A group health plan under this part shall comply with the notice requirement under section 1185(d) of title 29 with respect to the requirements of this section as if such section applied to such plan.

(e) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group or individual health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) Preemption; exception for health insurance coverage in certain States

(1) In general

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 300gg-23(d)(1)¹ of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) Construction

Section 300gg-23(a)(1)¹ of this title shall not be construed as superseding a State law described in paragraph (1).

(July 1, 1944, ch. 373, title XXVII, § 2725, formerly § 2704, as added Pub. L. 104-204, title VI, § 604(a)(3), Sept. 26, 1996, 110 Stat. 2939; renumbered § 2725 and amended Pub. L. 111-148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911.)

Editorial Notes

REFERENCES IN TEXT

Section 300gg-23 of this title, referred to in subsec. (f), was in the original section “2723”, and was translated as meaning section 2724 of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111-148, title I, §§ 1001(4), 1563(c)(14)(B), formerly § 1562(c)(14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

CODIFICATION

Section was formerly classified to section 300gg-4 of this title prior to renumbering by Pub. L. 111-148.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111-148, § 1563(c)(3)(A), formerly § 1562(c)(3)(A), as renumbered by Pub. L. 111-148,

¹ See References in Text note below.

§10107(b)(1), substituted “group or individual health insurance coverage” for “group health insurance coverage” in introductory provisions.

Subsec. (b). Pub. L. 111-148, §1563(c)(3)(B)(i), formerly §1562(c)(3)(B)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “group or individual health insurance coverage” for “group health insurance coverage in connection with a group health plan” in introductory provisions.

Subsec. (b)(1). Pub. L. 111-148, §1563(c)(3)(B)(ii), formerly §1562(c)(3)(B)(ii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “plan or coverage” for “plan”.

Subsec. (c)(2). Pub. L. 111-148, §1563(c)(3)(C)(i), formerly §1562(c)(3)(C)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “health insurance issuer offering group or individual health insurance coverage” for “group health insurance coverage offered by a health insurance issuer”.

Subsec. (c)(3). Pub. L. 111-148, §1563(c)(3)(C)(ii), formerly §1562(c)(3)(C)(ii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “health insurance issuer” for “issuer”.

Subsec. (e). Pub. L. 111-148, §1563(c)(3)(D), formerly §1562(c)(3)(D), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “group or individual health insurance coverage” for “group health insurance coverage”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 104-204, title VI, §604(c), Sept. 26, 1996, 110 Stat. 2941, provided that: “The amendments made by this section [enacting this section and amending sections 300gg-21 and 300gg-23 of this title] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.”

CONGRESSIONAL FINDINGS

Pub. L. 104-204, title VI, §602, Sept. 26, 1996, 110 Stat. 2935, provided that: “Congress finds that—

“(1) the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care; and

“(2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.”

§ 300gg-26. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit

If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan or coverage includes an aggregate lifetime limit on substantially all med-

ical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit

If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect

to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting pro-

vider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(6) Compliance program guidance document

(A) In general

Not later than 12 months after December 13, 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 1185a of title 29, and section 9812 of title 26, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled “Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance”.

(B) Examples illustrating compliance and noncompliance

(i) In general

The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable, based on investigations of violations of such sections, including—

(I) examples illustrating requirements for information disclosures and non-quantitative treatment limitations; and

(II) descriptions of the violations uncovered during the course of such investigations.

(ii) Nonquantitative treatment limitations

To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard

to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

(iii) Access to additional information regarding compliance

In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable; and

(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable.

(C) Recommendations

The compliance program guidance document shall include recommendations to advance compliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 1185a of title 29, or section 9812 of title 26, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

(D) Updating the compliance program guidance document

The Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable.

(7) Additional guidance

(A) In general

Not later than 12 months after December 13, 2016, the Secretary, the Secretary of

Labor, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 1185a of title 29, or section 9812 of title 26, as applicable.

(B) Disclosure

(i) Guidance for plans and issuers

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 1185a of title 29, or section 9812 of title 26, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

(ii) Documents for participants, beneficiaries, contracting providers, or authorized representatives

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

(C) Nonquantitative treatment limitations

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application

of nonquantitative treatment limitations to ensure compliance with this section, section 1185a of title 29, or section 9812 of title 26, as applicable, (and any regulations promulgated pursuant to such respective section), including—

(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

(II) limitations with respect to prescription drug formulary design; and

(III) use of fail-first or step therapy protocols;

(ii) examples of methods of determining—

(I) network admission standards (such as credentialing); and

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance

with this section, section 1185a of title 29, or section 9812 of title 26, as applicable.

(D) Public comment

Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

(8) Compliance requirements

(A) Nonquantitative treatment limitation (NQTL) requirements

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as “NQTLs”) on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

(B) Secretary request process**(i) Submission upon request**

The Secretary shall request that a group health plan or a health insurance issuer offering group or individual health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding non-compliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

(ii) Additional information

In instances in which the Secretary has concluded that the group health plan or health insurance issuer with respect to health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

(iii) Required action**(I) In general**

In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer—

(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or issuer is not in compliance; and

(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such coverage, has been determined to be not in compliance with this section.

(II) Exemption from disclosure

Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5.

(iv) Report

Not later than 1 year after December 27, 2020, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

(I) a summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to particular health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

(II) the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

(III) for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the requirements under this section;

(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

(V) the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

(C) Compliance program guidance document update process**(i) In general**

The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

(ii) Guidance and regulations

Not later than 18 months after December 27, 2020, the Secretary shall finalize any

draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

(iii) State

The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).

(b) Construction

Nothing in this section shall be construed—

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions

(1) Small employer exemption

This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 300gg-91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption

(A) In general

With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the

provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries

Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification

(i) In general

A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement

A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical

and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality

A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies

To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered

In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions

For purposes of this section—

(1) Aggregate lifetime limit

The term “aggregate lifetime limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit

The term “annual limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits

The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) Mental health benefits

The term “mental health benefits” means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits

The term “substance use disorder benefits” means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(July 1, 1944, ch. 373, title XXVII, § 2726, formerly § 2705, as added Pub. L. 104-204, title VII, § 703(a), Sept. 26, 1996, 110 Stat. 2947; amended Pub. L. 107-116, title VII, § 701(b), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107-313, § 2(b), Dec. 2, 2002, 116 Stat. 2457; Pub. L. 108-197, § 2(b), Dec. 19, 2003, 117 Stat. 2898; Pub. L. 108-311, title III, § 302(c), Oct. 4, 2004, 118 Stat. 1179; Pub. L. 109-151, § 1(b), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109-432, div. A, title I, § 115(c), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110-245, title IV, § 401(c), June 17, 2008, 122 Stat. 1650; Pub. L. 110-343, div. C, title V, § 512(b), (g)(2), Oct. 3, 2008, 122 Stat. 3885, 3892; renumbered § 2726 and amended Pub. L. 111-148, title I, § 1001(2), 1563(c)(4), formerly § 1562(c)(4), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911; Pub. L. 114-255, div. B, title XIII, § 13001(a), (b), Dec. 13, 2016, 130 Stat. 1278, 1280; Pub. L. 116-260, div. BB, title II, § 203(a)(1), Dec. 27, 2020, 134 Stat. 2900.)

Editorial Notes

CODIFICATION

Section was formerly classified to section 300gg-5 of this title prior to renumbering by Pub. L. 111-148.

AMENDMENTS

2020—Subsec. (a)(8). Pub. L. 116-260 added par. (8).

2016—Subsec. (a)(6), (7). Pub. L. 114-255 added pars. (6) and (7).

2010—Subsecs. (a), (b). Pub. L. 111-148, § 1563(c)(4)(A), (B), formerly § 1562(c)(4)(A), (B), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “or a health insurance issuer offering group or individual health insurance coverage” for “(or health insurance coverage offered in connection with such a plan)” wherever appearing.

Subsec. (c)(1). Pub. L. 111-148, § 1563(c)(4)(C)(i), formerly § 1562(c)(4)(C)(i), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “and a health insurance issuer offering group or individual health insurance coverage” for “(and group health insurance coverage offered in connection with a group health plan)”.

Subsec. (c)(2)(A). Pub. L. 111-148, § 1563(c)(4)(C)(ii), formerly § 1562(c)(4)(C)(ii), as renumbered by Pub. L. 111-148, § 10107(b)(1), substituted “or a health insurance issuer offering group or individual health insurance coverage” for “(or health insurance coverage offered in connection with such a plan)”.

2008—Pub. L. 110-343, § 512(g)(2), amended section catchline generally. Prior to amendment, catchline read as follows: “Parity in application of certain limits to mental health benefits”.

Subsec. (a)(1), (2). Pub. L. 110-343, § 512(b)(7), substituted “mental health or substance use disorder benefits” for “mental health benefits” wherever appearing in pars. (1)(introductory provisions), (A), and (B)(ii) and (2)(introductory provisions), (A), and (B)(ii).

Pub. L. 110-343, § 512(b)(6), substituted “mental health and substance use disorder benefits” for “mental

health benefits” wherever appearing in pars. (1)(B)(i) and (C) and (2)(B)(i) and (C).

Subsec. (a)(3) to (5). Pub. L. 110-343, § 512(b)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110-343, § 512(b)(7), substituted “mental health or substance use disorder benefits” for “mental health benefits”.

Subsec. (b)(2). Pub. L. 110-343, § 512(b)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: “in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) of this section (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).”

Subsec. (c)(1). Pub. L. 110-343, § 512(b)(3)(A), inserted “(as defined in section 300gg-91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual)” before period at end.

Subsec. (c)(2). Pub. L. 110-343, § 512(b)(3)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: “This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.”

Subsec. (e)(3). Pub. L. 110-343, § 512(b)(7), substituted “mental health or substance use disorder benefits” for “mental health benefits”.

Subsec. (e)(4). Pub. L. 110-343, § 512(b)(7), which directed substitution of “mental health or substance use disorder benefits” for “mental health benefits” wherever appearing in this section (other than in any provision amended by section 512(b)(6) of Pub. L. 110-343), was not executed to par. (4) as added by Pub. L. 110-343, § 512(b)(4), to reflect the probable intent of Congress. See below.

Pub. L. 110-343, § 512(b)(4), added par. (4) and struck out former par. (4). Prior to amendment, text read as follows: “The term ‘mental health benefits’ means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.”

Subsec. (e)(5). Pub. L. 110-343, § 512(b)(4), added par. (5).

Subsec. (f). Pub. L. 110-343, § 512(b)(5), struck out subsec. (f). Text read as follows: “This section shall not apply to benefits for services furnished—

“(1) on or after January 1, 2008, and before June 17, 2008, and

“(2) after December 31, 2008.”

Pub. L. 110-245 substituted “services furnished—” for “services furnished after December 31, 2007” and added pars. (1) and (2).

2006—Subsec. (f). Pub. L. 109-432 substituted “2007” for “2006”.

2005—Subsec. (f). Pub. L. 109-151 substituted “December 31, 2006” for “December 31, 2005”.

2004—Subsec. (f). Pub. L. 108-311 substituted “after December 31, 2005” for “on or after December 31, 2004”.

2003—Subsec. (f). Pub. L. 108-197 substituted “December 31, 2004” for “December 31, 2003”.

2002—Subsec. (f). Pub. L. 107-313 substituted “December 31, 2003” for “December 31, 2002”.

Pub. L. 107-116 substituted “December 31, 2002” for “September 30, 2001”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-343, div. C, title V, § 512(e), Oct. 3, 2008, 122 Stat. 3891, as amended by Pub. L. 110-460, § 1, Dec. 23, 2008, 122 Stat. 5123, provided that:

“(1) IN GENERAL.—The amendments made by this section [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act [Oct. 3, 2008], regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5) [amending this section, section 9812 of Title 26, and section 1185a of Title 29], relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

“(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Oct. 3, 2008], the amendments made by this section shall not apply to plan years beginning before the later of—

“(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

“(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.”

EFFECTIVE DATE

Pub. L. 104-204, title VII, § 703(b), Sept. 26, 1996, 110 Stat. 2950, provided that: “The amendments made by this section [enacting this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.”

REGULATIONS

Pub. L. 110-343, div. C, title V, § 512(d), Oct. 3, 2008, 122 Stat. 3891, provided that: “Not later than 1 year after the date of enactment of this Act [Oct. 3, 2008], the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c) [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor], respectively.”

IMPROVING COMPLIANCE

Pub. L. 114-255, div. B, title XIII, § 13001(d), Dec. 13, 2016, 130 Stat. 1283, provided that:

“(1) IN GENERAL.—In the case that the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury determines that a group health plan or health insurance issuer offering group or individual health insurance coverage has violated, at least 5 times, section 2726 of the Public Health Service Act (42 U.S.C. 300gg-26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), or section 9812 of the Internal Revenue Code of 1986 [26 U.S.C. 9812], respectively, the appropriate Secretary shall audit plan documents for such health plan or issuer in the plan year following the Secretary’s determination in order to help improve compliance with such section.

“(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority, as in effect on the day before the date of enactment of this Act [Dec. 13, 2016], of the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury to audit documents of health plans or health insurance issuers.”

CLARIFICATION OF EXISTING PARITY RULES

Pub. L. 114-255, div. B, title XIII, § 13007, Dec. 13, 2016, 130 Stat. 1287, provided that: “If a group health plan or

a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg-26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986 [26 U.S.C. 9812].”

ASSURING COORDINATION

Pub. L. 110-343, div. C, title V, §512(f), Oct. 3, 2008, 122 Stat. 3892, provided that: “The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that—

“(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor, and enacting provisions set out as notes under this section] (and the amendments made by this section) are administered so as to have the same effect at all times; and

“(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.”

Executive Documents

MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY TASK FORCE

Memorandum of President of the United States, Mar. 29, 2016, 81 F.R. 19015, provided:

Memorandum for the Heads of Executive Departments and Agencies

My Administration has made behavioral health a priority and taken a number of steps to improve the prevention, early intervention, and treatment of mental health and substance use disorders. These actions are especially important in light of the prescription drug abuse and heroin epidemic as well as the suicide and substance use-related fatalities that have reversed increases in longevity in certain populations. One important response has been the expansion and implementation of mental health and substance use disorder parity protections to ensure that coverage for these benefits is comparable to coverage for medical and surgical care. The Affordable Care Act builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act to expand mental health and substance use disorder benefits and Federal parity protections for more than 60 million Americans. To realize the promise of coverage expansion and parity protections in helping individuals with mental health and substance use disorders, executive departments and agencies need to work together to ensure that Americans are benefiting from the Federal parity protections the law intends. To that end, I hereby direct the following:

SECTION 1. *Mental Health and Substance Use Disorder Parity Task Force*. There is established an interagency Mental Health and Substance Use Disorder Parity Task Force (Task Force), which will identify and promote best practices for executive departments and agencies (agencies), as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and determine areas that would benefit from further guidance. The Director of the Domestic Policy Council shall serve as Chair of the Task Force.

(a) *Membership of the Task Force*. In addition to the Director of the Domestic Policy Council, the Task Force shall consist of the heads of the following agencies and offices, or their designees:

- (i) the Department of the Treasury;
- (ii) the Department of Defense;
- (iii) the Department of Justice;
- (iv) the Department of Labor;
- (v) the Department of Health and Human Services;
- (vi) the Department of Veterans Affairs;
- (vii) the Office of Personnel Management;
- (viii) the Office of National Drug Control Policy; and
- (ix) such other agencies or offices as the President may designate.

At the request of the Chair, the Task Force may establish subgroups consisting exclusively of Task Force members or their designees under this section, as appropriate.

(b) *Administration of the Task Force*. The Department of Health and Human Services shall provide funding and administrative support for the Task Force to the extent permitted by law and within existing appropriations.

SEC. 2. *Mission and Functions of the Task Force*. The Task Force shall coordinate across agencies to:

- (a) identify and promote best practices for compliance and implementation;
- (b) identify and address gaps in guidance, particularly with regard to substance use disorder parity; and
- (c) implement actions during its tenure and at its conclusion to advance parity in mental health and substance use disorder treatment.

SEC. 3. *Outreach*. Consistent with the objectives set out in section 2 of this memorandum, the Task Force, in accordance with applicable law, shall conduct outreach to patients, consumer advocates, health care providers, specialists in mental health care and substance use disorder treatment, employers, insurers, State regulators, and other stakeholders as the Task Force deems appropriate.

SEC. 4. *Transparency and Reports*. The Task Force shall present to the President a report before October 31, 2016, on its findings and recommendations, which shall be made public.

SEC. 5. *General Provisions*. (a) The heads of agencies shall assist and provide information to the Task Force, consistent with applicable law, as may be necessary to carry out the functions of the Task Force.

(b) Nothing in this memorandum shall be construed to impair or otherwise affect:

- (i) the authority granted by law to an executive department, agency, or the head thereof; or
 - (ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.
- (c) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.
- (d) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(e) The Secretary of Health and Human Services is authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA.

§ 300gg-27. Required coverage for reconstructive surgery following mastectomies

The provisions of section 1185b of title 29 shall apply to group health plans, and and¹ health insurance issuers offering group or individual health insurance coverage, as if included in this subpart.

(July 1, 1944, ch. 373, title XXVII, §2727, formerly §2706, as added Pub. L. 105-277, div. A, §101(f) [title IX, §903(a)], Oct. 21, 1998, 112 Stat. 2681-337,

¹ So in original.

2681-438; renumbered §2727 and amended Pub. L. 111-148, title I, §§1001(2), 1563(c)(5), formerly §1562(c)(5), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

Editorial Notes

CODIFICATION

Section was formerly classified to section 300gg-6 of this title prior to renumbering by Pub. L. 111-148.

AMENDMENTS

2010—Pub. L. 111-148, §1563(c)(5), formerly §1562(c)(5), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “and health insurance issuers offering group or individual health insurance coverage” for “health insurance issuers providing health insurance coverage in connection with group health plans”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 105-277, div. A, §101(f) [title IX, §903(c)(1)], Oct. 21, 1998, 112 Stat. 2681-337, 2681-438, provided that: “(A) IN GENERAL.—The amendment made by subsection (a) [enacting this section] shall apply to group health plans for plan years beginning on or after the date of enactment of this Act [Oct. 21, 1998].

“(B) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.”

§ 300gg-28. Coverage of dependent students on medically necessary leave of absence

(a) Medically necessary leave of absence

In this section, the term “medically necessary leave of absence” means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or individual health insurance coverage, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 1002 of title 20), or any other change in enrollment of such child at such an institution, that—

- (1) commences while such child is suffering from a serious illness or injury;
- (2) is medically necessary; and
- (3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) Requirement to continue coverage

(1) In general

In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that offers group or individual health insurance coverage, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

- (A) the date that is 1 year after the first day of the medically necessary leave of absence; or
- (B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) Dependent child described

A dependent child described in this paragraph is, with respect to a group health plan or individual health insurance coverage, a beneficiary under the plan who—

(A) is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and

(B) was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) Certification by physician

Paragraph (1) shall apply to a group health plan or individual health insurance coverage only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) Notice

A group health plan, and a health insurance issuer that offers group or individual health insurance coverage, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) No change in benefits

A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) Continued application in case of changed coverage

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or individual health insurance coverage, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(July 1, 1944, ch. 373, title XXVII, §2728, formerly §2707, as added Pub. L. 110-381, §2(b)(1), Oct. 9, 2008, 122 Stat. 4083; renumbered §2728 and amended Pub. L. 111-148, title I, §§1001(2), 1563(c)(6), formerly §1562(c)(6), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

Editorial Notes

CODIFICATION

Section was formerly classified to section 300gg-7 of this title prior to renumbering by Pub. L. 111-148.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-148, §1563(c)(6)(A), formerly §1562(c)(6)(A), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered in connection with such plan” in introductory provisions.

Subsec. (b)(1). Pub. L. 111-148, §1563(c)(6)(B)(i), formerly §1562(c)(6)(B)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “or a health insurance issuer that offers group or individual health insurance coverage” for “or a health insurance issuer that provides health insurance coverage in connection with a group health plan” in introductory provisions.

Subsec. (b)(2). Pub. L. 111-148, §1563(c)(6)(B)(ii), formerly §1562(c)(6)(B)(ii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered in connection with the plan” in introductory provisions.

Subsec. (b)(3). Pub. L. 111-148, §1563(c)(6)(B)(iii), formerly §1562(c)(6)(B)(iii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered by an issuer in connection with such plan”.

Subsec. (c). Pub. L. 111-148, §1563(c)(6)(C), formerly §1562(c)(6)(C), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “health insurance issuer that offers group or individual health insurance coverage” for “health insurance issuer providing health insurance coverage in connection with a group health plan”.

Subsec. (e)(1). Pub. L. 111-148, §1563(c)(6)(D), formerly §1562(c)(6)(D), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered in connection with such a plan”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110-381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

PART B—INDIVIDUAL MARKET RULES

SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

§ 300gg-41. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage

(a) Guaranteed availability

(1) In general

Subject to the succeeding subsections of this section and section 300gg-44 of this title, each health insurance issuer that offers health insurance coverage (as defined in section 300gg-91(b)(1) of this title) in the individual market in a State may not, with respect to an

eligible individual (as defined in subsection (b)) desiring to enroll in individual health insurance coverage—

(A) decline to offer such coverage to, or deny enrollment of, such individual; or

(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A))¹ with respect to such coverage.

(2) Substitution by State of acceptable alternative mechanism

The requirement of paragraph (1) shall not apply to health insurance coverage offered in the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 300gg-44 of this title.

(b) “Eligible individual” defined

In this part, the term “eligible individual” means an individual—

(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c))¹ is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], or (C) a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or any successor program), and does not have other health insurance coverage;

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b)¹ (relating to nonpayment of premiums or fraud);

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) Alternative coverage permitted where no State mechanism

(1) In general

In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 300gg-44 of this title, the health insurance issuer may elect to limit the coverage offered under subsection (a) so long as it offers at least two different policy forms of health insurance coverage both of which—

(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

¹ See References in Text note below.